

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE OF MISSOURI

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 123 **63-032091**

**FILED SEP 3 1963**

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains,</u>		Length of stay in 1b <u>hours</u>	c. CITY OR TOWN <u>Hocomo</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>W.P. Memorial Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Hocomo</u>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Chester Grant Duffell</u>			4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1963</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-30-1920</u>	9. AGE (last birthday) <u>43 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lathe operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Amux Mfg. Co.</u>	11. BIRTHPLACE (City and state or country) <u>Brandsville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Joe Duffell</u>		13b. MOTHER'S MAIDEN NAME <u>Della Falmsbee</u>		14. NAME OF HUSBAND OR WIFE <u>Oma Lee Claude</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates)		16. SOCIAL SECURITY NO. <u>649</u>	17. INFORMANT Address <u>Mrs. Chester Duffell, Hocomo, Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound - self inflicted 23 hrs</u> DUE TO (b) <u>FRacture, Skull, due to above</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Psychosis - Schizophrenia</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Shot SELF Forehead 22 caliber</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from Oct 1962 to August 1963 last saw him alive on 8-23-63  
Death occurred at 11:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Jack M. Wiles, M.D.</u>	(Degree or title)	22b. ADDRESS <u>West Plains, Mo.</u>	22c. DATE SIGNED <u>8-23-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>	23b. DATE <u>8-22-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Amy Union Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Hocomo, Mo.</u>

24. FUNERAL DIRECTOR <u>Robertsons, West Plains, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8-26-63</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Wiles

SEP 4 1963

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

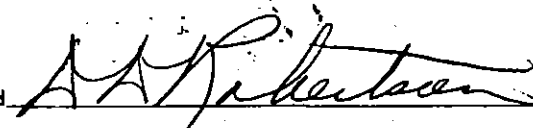
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 3432

P. O. Address West Plains, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.